Commonwealth of Massachusetts
Executive Office of Health and Human Services

June 2008 *Version 3.0*

Companion Guide

Health Care Payment/Advice

For X12N 835 (Version 4010A1)

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 – Administrative Simplification (HIPAA-AS) – requires that MassHealth, and all other health-insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. X12N 835 Version 4010A1 is the standard established by HHS for the payment of claims and the transfer of remittance advice data.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 835 Payment/Advice transaction specifies in detail the required formats for payments and remittance advices transmitted electronically by payers. It contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to receive HIPAA-compliant files from MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The Implementation Guides for X12N 835 Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of This Companion Guide

This companion guide was created for MassHealth trading partners by MassHealth to supplement the 835 Implementation Guide. It contains MassHealth-specific information for the following:

- data content, codes, business rules, and characteristics of the 835 transaction;
- technical requirements and transmission options; and
- information on DMA test support available to Trading partners.

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for receiving electronic remittance advices from MassHealth. In addition, this information should be shared with the provider's billing office to ensure all accounts are reconciled in a timely manner.

2.0 Establishing Connectivity with MassHealth

All MassHealth trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a trading partner profile (TPP) form prior to receiving an electronic 835 transaction. Note that TPP information may be given over the telephone or via the Web portal in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.2 – Support Contact Information) if you have any questions about these forms.

2.1 Setup

MassHealth trading partners should submit HIPAA 835 transactions to MassHealth via the Provider Online Service Center, or system-to-system using our Healthcare Transaction Service (HTS) process. Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options and to obtain a copy of the HTS guide

After establishing a transmission method, each trading partner must successfully complete trading partner testing. Information on this phase is provided in the next section of this companion guide.

Each 835 transaction will be available for trading partners to download from the transaction Web site for at least 90 days. Trading partners requiring access to their 835s beyond the 90-day period should contact MassHealth Customer Service. (See Section 2.2 – Support Contact Information)

2.2 Support Contact Information

For questions regarding any issues in this companion guide, providers may contact MassHealth Customer Service by mail, phone, fax, or e-mail.

MassHealth Customer Service
P.O. Box 9118
Hingham, MA 02043
E-mail: hipaasupport@mahealth.net
Phone: 1-800-841-2900
Fax: 617-988-8971

3.0 Technical Requirements

MassHealth will send all fully adjudicated claims from a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

This limit of 10,000 CLP segments is a recommendation for the 835 transaction, but not a requirement. Trading partners, especially those handling a large claim volume, are encouraged to proactively test their compliance software internally to ensure it allows over 10,000 CLP segments in one 835 transaction.

Each 835 transaction is sent in a separate ISA/IEA envelope. For clearinghouses with multiple providers, multiple ST/SEs will be generated under the same ISA/IEA. However, MassHealth sends more than one ISA/IEA envelope in one file. For example, if a clearinghouse has been selected to receive three of their clients' 835s, the structure will be as follows:

- ISA Clearinghouse 123
- GS Clearinghouse 123
- ST Provider A
- SE
- ST Provider B
- SE
- ST Provider C
- SE
- GE
- IEA

3.1 General Information for Member Name

The member name segment accepts and returns 30 characters as required in the Implementation Guide. However, If a value is submitted on a transaction that is greater than what is stored in the NewMMIS member database, on the return transaction the following would occur:(a) if a match is found on the database, the value stored on the database table is returned; (c) if no match is found on the database, the value stored on the original incoming transaction will be returned.

Example
A provider submits an eligibility verification check (270) with a name that is 22 characters long, but the database currently stores only 20 of those characters. On the return transaction (271), the provider will receive only the first 20 characters of the name submitted, if a match is found on the database. If for some reason, the member name submitted is not a MassHealth member, and is not stored on the database (no match found), on the return transaction (271) the name would be returned exactly as it was originally submitted.

4.0 MassHealth-specific Requirements

The 835 transaction is available to those providers with a valid MassHealth provider number and a signed Trading Partner Agreement on file. 835 transactions are generated at the completion of each weekly claims adjudication cycle for each provider that has at least one paid or denied claim appearing in the weekly cycle. Information about pended or suspended claims can be obtained from the MassHealth proprietary remittance advice, or via the 276/277 Claims Status Inquiry and Response transactions, which can be found on the Provider Online Service Center. Since an 835 transaction must balance to a single check/electronic funds transfer (EFT), MassHealth is obligated to include all fully adjudicated claims from a weekly cycle, regardless of how the claim was submitted (paper, proprietary electronic format, or as an 837 transaction). As usual, the State Comptroller sends the payment check or EFT separately.

4.1 Payment and Remittance Schedule

There is no change to the weekly disbursement schedule for check or EFT payments. 835s are available for retrieval each week.

4.2 835 Transactions in Response to Dental Claims

Dental providers submitting both dental and medical claims receive a separate payment and a separate 835 for their dental and medical claims. 835s for dental claims are generated and distributed by Doral, a third party vendor. Thus, dental claim payments are no longer combined with MassHealth payments. Information about the Dental 835 transaction can be requested from www.masshealth-dental.net or by calling 1-800-207-5019. Support contact information for Doral is as follows.

Doral Dental / MassHealth Dental Program
12121 N. Corporate Parkway
Mequon, WI 53092

4.3 835 Transactions in Response to Retail Pharmacy Claims

Retail pharmacy providers submitting both pharmaceutical and durable medical equipment (DME) will receive their payment and 835 from MassHealth. Information about the contents in the retail pharmacy 835 transaction can be requested via e-mail to <***TBD***> or by calling <***TBD***>.

4.4 Retroactive Pay Cycles

When a retro cycle produces a separate payment from the regular weekly claims run, a separate 835 transaction is also produced.

4.5 Production File-naming Convention

835 files produced by MassHealth have the following naming convention:
XXXXXXXXXX.835.WEB.hhmmssnnn.jjj, where

- XXXXXXXXXX is the trading partner ID;

- hhmmss is the time stamp;
- nnn is the sequence number; and
- jjj is the julian day.

4.6 MassHealth CLP Segment Implementation

835s can also be generated without any CLP and SVC. This will be the 835 for providers with no claim activity, but with provider level adjustments. An 835 transaction has one Loop 1000A, one Loop 1000B, multiple iterations of Loop 2000*, multiple iterations of Loop 2100*, and multiple iterations of Loop 2110*.

*** If there is only one fully adjudicated claim for a provider, there will be only one iteration of this segment.**

If the sum of the claim payment amounts (CLP04s) on the 835 transaction is positive, then a check or EFT payment is produced. One check or one EFT payment must balance to one 835 transaction. As a result, each 835 can have only one ST and SE segment. MassHealth produces all of a provider's paid and/or denied claims in a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

If the sum of the claim payment amounts (CLP04s) on the 835 is zero or negative, no check or EFT payment is sent. The 835 is still produced, but the financial fields are zero filled, as they will not be applicable.

5.0 Detail Data

Although submitters can view the entire set of required data elements in the 835 Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments.

Loop	Segment		Segment Name	Element Name	Companion Information
----	ISA	01	----	Authorization Information Qualifier	"00"
----	ISA	02	----	Authorization Information	10 blanks
----	ISA	03	----	Security Information Qualifier	"00"
----	ISA	04	----	Security Information	10 blanks
----	ISA	05	----	Interchange Sender ID Qualifier	"ZZ"
----	ISA	06	----	Interchange Sender ID	Trading partner ID assigned by MassHealth (either the nine-digit MassHealth provider number plus service location, or NPI)
----	ISA	07	----	Interchange Receiver ID Qualifier	"ZZ"
----	ISA	08	----	Interchange Receiver ID	"DMA7384"
----	ISA	14	----	Acknowledgement Requested	"0"
----	ISA	15	----	Usage Indicator	"P" for production submission; "T" for test submission
----	IEA	01	----	Number of included Functional Groups	Must equal "1" for the interactive transaction to qualify for immediate response.
----	GS	02	----	Application Sender's Code	Trading partner ID assigned by MassHealth (the 9-digit MassHealth provider number plus service location or NPI)
----	GS	03	----	Application Receiver's code	"DMA7384"
----	GE	01	----	Number of transactions included	Must equal "1" for the interactive transaction to qualify for immediate response.
Header	ST	02	Transaction Set Header	Transaction Set Control Number	Translators will auto-fill this field. Within each GS/GE, ST02 starts with (GS06 X 1000) + 1 and is incremented by one for the ST02s that follow.

Loop	Segment		Segment Name	Element Name	Companion Information
Header	BPR	01	Financial Information	Transaction Handling Code	When the total payment amount (BPR02) is greater then zero, BPR01 contains **"I" (Remittance Information Only).** When the total payment amount (BPR02) is zero, BPR01 contains an **"H"** (**Notification Only).** For state transfers, this will always be "H."
Header	BPR	04	Financial Information	Payment Method Code	This will be populated with "ACH" when BPR01 = "I." This will be populated with "NON" when BPR01 = "H."
Header	BPR	05	Financial Information	Payment Format Code	For providers receiving payments electronically, this is "CTX" (Corporate Trade Exchange).
Header	BPR	11	Financial Information	Originating Company Supplemental Code	This field is used by MassHealth for tracking purposes to assist in issue resolution. It is populated with a voucher number from MMARs.
Header	REF	02	Receiver Identification	Receiver Identifier	This data element is used only when the Payee is not the same as the receiver of the 835. MassHealth returns the 835 receiver's number you provided on your trading partner profile form.
Header	DTM	01	PRODUCTION DATE	Date/Time Qualifier	This field will always contain the value of "405" for production.
Header	DTM	02	PRODUCTION DATE	Date	This attribute is also known as the Financial Run Date. The run date is calculated based on the system date in which the financial cycle was initiated.
1000A	REF	01	PAYER IDENTIFICATION	Entity Identifier Code	This value is always "PR."
1000A	REF	02	PAYER IDENTIFICATION	Name	This value is always "commonwealth of massachusetts/eohhs/office of medicaid".
1000A	PER	06	PAYER CONTACT INFORMATION	Payer Contact Communication Number	The phone number on the 835 will be for Medicaid customer service; however, if the questions are about a pharmacy claim, the ACS phone number (617-423-9830) should be used.
1000A	PER	08	PAYER CONTACT INFORMATION	Payer Contact Communication Number	The e-mail on the 835 will be for Medicaid customer service; however, if the question are about a pharmacy claim, the ACS e-mail (MassHealth.Providerrelations@acs-inc.com) should be used
1000B	N1	04	Identification Code	Payee Identification Code	This segment requires provider NPI. For atypical providers, enter provider tax ID.
1000B	N3	01	Payee Identification	Payee Address Line	MassHealth returns the billing address on file for you.

Loop	Segment		Segment Name	Element Name	Companion Information
1000B	N4 N4 N4	01 02 03	Payee City, State, Zip Code	Payee City Payee State Payee Zip Code	MassHealth returns the billing address we have on file for you.
1000B	REF	01	Additional Payee Identification	Reference Identification Qualifier	Enter TJ = "Federal Tax Payer's Identification Number" when 1000B:N104 is not blank and N104 = NPI.
2100	CLP	01	Claim Payment Information	Patient Control Number	**For claims received on an 837**, MassHealth returns the data in Loop 2300 CLM01 on the 837. **For paper and electronic claims:** MassHealth returns the patient control number or the patient account number. If this field is left blank on the incoming claim, then we return zeros.
2100	CLP	09	Claim Payment Information	Claim Frequency Code	This data element will be used only for Institutional claims. **For claims received on an Institutional 837,** MassHealth returns the data in Loop 2300 CLM05-3 on the 837. **For paper and EMC claims received on a UB04 form**, MassHealth returns the 3rd position of the bill type.
2100	NM1 NM1 NM1 NM1	03 04 05 07	Patient Name	Patient Last Name Patient First Name Patient Middle Name Patient Name Suffix	**For claims received on an 837,** MassHealth returns the patient name information that you provided in Loop 2010BA NM103, NM104, NM105, and NM107. **For paper and electronic claims,** MassHealth returns the patient name information that we have on file in our claims processing system. MassHealth does not return a patient name suffix, as we do not store this information in our system. If the member number that you provide does not find a match in our system, we populate the patient last name (NM103) and patient first name (NM104) data elements with "name missing."
2100	NM NM NM	03 04 05	Corrected Patient / Insured Name	Corrected Patient Last Name Corrected Patient First Name Corrected Patient Middle Name	This segment is populated when there is a discrepancy in the name information submitted on the claim (NM1) and the member file. This will be done for both paper and electronic (837) submissions. Paper claims will map to the NM1 segment as the name will be extracted on the paper submission. If the first name and/or last name is missing, "name missing" will be populated.

Loop	Segment		Segment Name	Element Name	Companion Information
2100	NM1 NM1 NM1 NM1	03 04 05 07	Service Provider Name	Rendering Provider Last or Organization Name Rendering Provider First Name Rendering Provider Middle Name Rendering Provider Name Suffix	MassHealth returns the name we have on file for the rendering provider.
2100	REF	02	Other Claim Related Information	Other Claim Related Identifier	If applicable to the claim, MassHealth returns the following information. 1. **Medical Record Number:** REF01 = "EA" REF02 = the inpatient or outpatient medical record number 2. **Social Security Number:** REF01 = "SY" REF02 = the member social security number 3. **Prior Authorization Number:** REF01 = "G1" REF02 = the 6-character prior authorization number 4. **Former TCN:** REF01 = "F8" REF02 = the 10-character former TCN 2 5. **TPL Policy Number :** REF01 = "IL" REF02 = The TPL policy number There can be up to 3 iterations of TPL policy numbers depending on the presence or lack of the other criteria populating this segment. There may be zero to five iterations of this segment, depending on how many of the above criteria are met.
2100	DTM	02	Claim Date	Claim Date	For medical claims this will be date of service. For pharmacy claims this will be populated with date dispensed

Loop	Segment		Segment Name	Element Name	Companion Information
2110	SVC SVC	01-1 01-2	Service Payment Information	Product/Service ID Qualifier Procedure Code	In order to provide the most detailed information to providers on why a claim denied, MassHealth supplies remark codes when applicable on all denied claims. To include remark codes, the 835 Implementation Guide mandates that we also provide service line information. The following is a list of defaults we use, if the incoming claim is missing this required data. For 837-Dental claims: SVC01-1: "AD" SVC01-2: procedure code For 837-Professional claims, a HCPCS code is provided: SVC01-1: "HC" SVC01-2: service code For certain 837-Institutional claims or claims received on a UB04 form, if no HCPCS a revenue code is provided: SVC01-1: "UN" SVC01-2: revenue code For a professional or institutional claim, both a service and a revenue code are provided: SVC01-1: "HC" SVC01-2: service code SVC04: revenue code
2110	DTM	02	Service Date	Service Date	If you provide an invalid date such as spaces or "20020231," we return 99990101.
2110	CAS	01-1 8	Service Ajustement	Claim Adjustment Group Code Adjustment Reason Code Adjustment Amount	This segment is used only if the charges do not equal what MassHealth paid. MassHealth always details any differences at the service level CAS segment (Loop 2110). For denied claims see the Denied Claims section below this table.
2110	REF REF	01 02	Service Identification	Reference Identification Qualifier Reference Identification	For claims received on an 837, MassHealth returns the following information: The reference identification qualifier is always "6R."
2110	AMT	01 02	Service Supplemental Amount	**Amount Qualifier Code**	**AMT01** –"B6" - Allowed – Actual **AMT02 -** Allowed amount from the service line

Loop	Segment		Segment Name	Element Name	Companion Information
2110	LQ	01, 02	Health Remark Codes		There are as many iterations of the LQ segment as needed to accommodate each unique remark code associated with the claim. LQ01 is always "HE." LQ02 will contain each unique remark code associated with the claim.
summary	PLB PLB PLB PLB PLB	01 02 03-1 03-2 04	Provider Adjustment	Provider Identifier Fiscal Period Date Adjustment Reason Code Provider Adjustment Identifier Provider Adjustment Amount	This segment is used only if there are non-claim related adjustments and/or adjustments made by MMARS. PLB01: **"72" - Authorized Return** **"CT" - for Capitation Payment** **"FB" - for Forwarding Balance** **"IR" - Internal Revenue Service Withholding** **"LE" - Levy** **"WO" - Overpayment Recovery** **"CS" - Adjustment-** will be used to identify an adjustment applied to payment due the MMARS system. PLB03: All the "9"s will be populated here when a MMARS adjustment has been performed (PLB01 = "CS").

Denied Claims: Loop 2110 CAS - Service Adjustment Details

Denied claims with another paid amount equal to the billed amount will not report the other paid amount, but spread the denied amount across the cross-walked denied edits.

If a denied claim has a non-zero other paid amount, and the other paid amount is not equal to the billed amount. The other paid amount will be reported as an adjustment, and then the remaining dollars will be divided across the cross-walked denied edits.

If a denied claim has a non-zero other paid amount, and the other paid amount is equal to the billed amount. The other paid amount will not be reported as an adjustment, and all the adjustment dollars will be divided across the cross-walked denied edits.

Here are examples of how this will work:

Claim 1:

Billed amount = $100.00
Other paid amount = $80
Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments:
Other paid amount = $80
AA = $10
BB = $10

Claim 2:

Billed amount = $100.00
Other paid amount = $100.00
Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments:
AA = $50
BB = $50

Claim 3:

Billed amount = $100.00
Other paid amount = $120.00
Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments:
Other paid amount = $120.00
AA = -$10
BB = -$10

Table 1. Sample of NewMMIS Edit Code Crosswalks

Current NewMMIS Edit Code	Adjustment Reason Code	Remark Code
241	A1	M58
814	16	MA61
1055	52	M68
020	52	M68
6001	B13	

CAS03, CAS06, etc.: MassHealth returns in CAS03, CAS06, etc. the difference between SVC03 and SVC02, divided by the number of adjustment reason codes associated with the claim. For example, please assume claim segment SVC03 – SVC02 = $300.25, and the MMIS edits in Table 1 are generated. Since there are three unique adjustment reason code/remark code pairs, $300.25 is divided by 3.

For the claim that generates MMIS edit codes 241, 814, 1055 and 020 in the above example, the CAS and the LQ segments on the 835 appear as follows:

- CAS*CO*16*100.25**52*100**A1*100~
- LQ*HE*MA61~
- LQ*HE*M68~
- LQ*HE*M58~

MMIS edit code 6007 has no LQ segment because it does not have a corresponding remark code.

MMIS edit code 020 has no CAS and LQ segments because it has the same adjustment reason code/remark code pair as MMIS edit code 1055, thus it is not reported twice.

For denied claims that do not have a CAS segment (CLP03 = CLP04 and SVC02 = SVC03)

There are as many iterations of the LQ segment as there are needed to accommodate up to 99 unique remark codes.

LQ01: LQ01 is always “HE.”
LQ02: In LQ02, MassHealth returns each unique remark code associated with the claim.

6.0 Sample MassHealth 835 Transactions

ISA*00* *00* *ZZ*DMA7384 *ZZ*0121212 *030929*2315*U*00401*000000555*1*P*>~
GS*HP*DMA7384*0121212*20030929*231542*168*X*004010X091A1~
ST*835*000000021~
BPR*I*72.18*C*CHK*******V00100100*****20030925~
TRN*1*00052224165*1046002284~
DTM*405*20030929~
N1*PR*Commonwealth of Massachusetts/MassHealth*XV*046002284EHS***~
N3*600 Washington Street~
N4*Boston*MA*02111~
PER*CX*MassHealth Provider Services*TE*8003255231*EM*EDI@MAHealth.Net~
N1*PE*ACME MEDICAL CORP*FI*04952236~
N3*10 HIPAA LANE~
N4*BOSTON*MA*02111~
REF*1D*0121212~
LX*1~
CLP*1110001*1*100*62.18*10*MC*3272A0401A*11~
NM1*QC*1*DAWSON*WILMA****MR*0099965421~
DTM*050*20030929~
DTM*232*20030814~
SVC*HC:99214*100*62.18**1~
DTM*472*20030814~
CAS*PR*142*10~
CAS*CO*42*27.82~
LX*2~
CLP*1110002*1*100*72.18**MC*3272A0412A*11~
NM1*QC*1*JONES*JOE****MR*0087874444~
NM1*74*1*JONES*JOSEPH~
DTM*050*20030929~
DTM*232*20030822~
SVC*HC:99214*100*72.18**1~
DTM*472*20030822~
CAS*CO*42*27.82~
LX*3~
CLP*1110005*4*100*0**MC*3272A0414A*11~
NM1*QC*1*BAYLOR*RAYMOND*C**III*MR*0033014420~
NM1*74*1*BAYLOR*RAYMOND*C~
DTM*050*20030929~

MassHealth 835 Transaction Example (cont.)

DTM*232*20030814~
SVC*HC:99214*100*0**1~
DTM*472*20030814~
CAS*CO*47*100~
LQ*HE*MA63~
LX*4~
CLP*1110012*4*100*0**MC*3272A0415A*11~
NM1*QC*1*LEE*MIMI*L***MR*0067777258~NM1*74*1*LEE*MIMI*L~
DTM*050*20030929~
DTM*232*20030814~
SVC*HC:99214*100*0**1~
DTM*472*20030814~
CAS*CO*47*50**A1*50~
LQ*HE*MA63~
LQ*HE*M62~
LX*5~
CLP*1110014*22*-100*-62.18**MC*3272A0419A*11~
NM1*QC*1*JENSON*STANLEY*A***MR*022228371~
REF*F8*FORMER-TCN-3177F1804A~
DTM*050*20030929~
DTM*232*20030812~
SVC*HC:99214*-100*-62.18~
DTM*472*20030812~
CAS*CR*125*-37.82~
REF*6R*A~
SE*64*101700021~
GE*1*168~
IEA*1*000000555~

7.0 Version Table

Version	Date	Section/Pages	Description
0.5	02/13/03		Initial document created
1.0	02/26/03	Entire Document	Revision with updated MassHealth template
1.1	03/25/03	Entire Document	Revision with additional formatting meeting CG Workgroup standards
1.2	05/21/03	Entire Document	Submitted to CG Workgroup for draft review
1.3	08/29/03	Entire Document	Updated and revised
1.4	10/08/03	Entire Document	Final draft revisions incorporated and draft production version issued
1.5	05/28/04	Headers/footers throughout document, Section 7.0 and Section 4.0	Final draft revisions incorporated and draft production version issued
1.6	11/32/04	Updated headers, Sections 1.4, 2.0, 4.0, 5.0, 7.0 and 7.1 to reflect SFDA information	Final draft revisions incorporated and draft production version issued
1.7	05/19/05	Updates made to Sections 4.0 and 6.0 to reflect TPA 60-day Noticing.	Draft version issued. Production version to follow.
1.8	06/24/05	Updated Sections 5.0 and 6.0 to reflect new e-mail addresses.	Draft version issued. Production version to follow.
2.0	04/01/08	Updates made to entire document	Significant revisions throughout guide to reflect NewMMIS requirements
3.0	06/08	Updates made to entire document	Additional revisions throughout guide to reflect NewMMIS requirements, based on feedback from Version 2.0

Appendix A: Frequently Asked Questions

Q. Will I still continue to receive my MassHealth paper remittance advice?
A. We will no longer be mailing paper remittance advices. They will be available in Adobe PDF file format so you will be able to download them to your own computer, view them, and print them if you like. This MassHealth PDF remittance advice will continue to provide information about suspended claims, in addition to information about paid and denied claims that appear on your 835 electronic transaction.

Q. Do I have to receive an 835 remittance response if I submit my claims electronically?
A. No. You can submit an 837 transaction, but elect to not receive the 835 response. You will still receive the PDF remittance advice (as described above).

Q. Will any paper claims I submit also appear on the 835?
A. Yes. All paid and denied claims adjudicated in the weekly cycle will appear, regardless of how they were submitted.

Q: Will suspended and pended claims appear on the 835?
A: No. **S**uspended and pended claims will appear only on the PDF remit.

Q. Can I have my billing intermediary receive my 835?
A. Yes. As long as you indicate that in your TPP information.

Appendix B: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)
- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

Association for Electronic Health Care Transactions (AFEHCT)
- A health care association dedicated to promoting the interchange of electronic health care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)
- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/.
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMO)
- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

MassHealth Provider Services
- This site assists providers with MassHealth billing and policy questions, as well as provider enrollment. www.mass.gov/masshealth

Office for Civil Rights (OCR)
- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)
- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)
- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)
- WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org